

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10579 **CERTIFICATE OF DEATH**

10572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u> c. LENGTH OF STAY IN 1b <u>4 days.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton.</u> 05X-2 d. STREET ADDRESS <u>North 6th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas</u> <u>R</u> <u>Benson.</u>		4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1958</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1979</u> 9. AGE (In years last birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ice cream.</u>			
11. BIRTHPLACE (State or foreign country) <u>Delaware</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel Benson.</u> 14. MOTHER'S MAIDEN NAME <u>Laveria Germann.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT <input type="checkbox"/> Address <input type="checkbox"/>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Jaundice and ascites of undetermined origin</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>58</u> , to <u>9-17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-17</u> , 19 <u>58</u> , and that death occurred at <u>9:53 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u>Robert W. Trever</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D. <u>202 Dover St.</u> PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u> <u>EASTON</u> <u>M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Sep-20, 1958</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u> 22d. LOCATION (City, town, or county) (State) <u>Denton Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. ...</u> ADDRESS <u>...</u> 24a. REC'D BY REGISTRAR <u>SEP 23 '58</u> 24b. REGISTRAR'S SIGNATURE <u>...</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10573

10600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY TALBOT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON rural		c. LENGTH OF STAY IN I.K. Entire Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tredavon River			e. STREET ADDRESS 1120 BLAKE St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) JAMES A Boyce			4. DATE OF DEATH Month 9- Day 13 Year 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1913	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIME KEEPER.		10b. KIND OF BUSINESS OR INDUSTRY J. JULIAN Conn. Talbot Co		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Harvey E. Boyce			14. MOTHER'S MAIDEN NAME Mary Lowers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-14-8507		17. INFORMANT Miss James Boyce Easton Md.	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 975X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 9-13 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) TREDAVON R. NR. EASTON TALBOT MD		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Louis M. WELT		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-14-58	
EXAMINER'S NAME (Type) WELT		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, RE-INTERMENT Buried		22b. DATE THEREOF 9/14/58		22c. NAME OF CEMETERY OR CREMATORY Spring Hill	
22d. LOCATION (City, town, or county) Easton Md.		22e. REGISTRAR'S SIGNATURE Arthur L. Frank		22f. DATE SEP 19 1958	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman & Son Easton Md.					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10574

10601

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRBANK</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fairbank</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Rural.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET ANN BRADSHAW</u>				4. DATE OF DEATH Month Day Year <u>Sept 25 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 31 1867</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Talbot Co. md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Gorman Cummings, Fairbank md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>advanced age</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. <u>5:45</u> <u>5</u> 19 <u>58</u> p. m.				20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1954</u> to <u>Sept 24, 1958</u> , that I last saw the deceased alive on <u>Sept 24, 1958</u> , and that death occurred at <u>4:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>GUY M REESER</u> M.D.				ADDRESS (Street, city or town, state) <u>Talbot md</u>			
DATE SIGNED <u>SEP 25 1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 25, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Church</u>		22d. LOCATION (City, town, or county) (State) <u>Fairbank md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Hawtorn Harrison, St. Michaels md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10602

CERTIFICATE OF DEATH

10576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>ROYAL OAK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIO-VISTA NURSING HOME</u>		d. STREET ADDRESS <u>1 RURAL</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET T. CULLIEN</u>		4. DATE OF DEATH Month Day Year <u>SEPT 10 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 13, 1869</u>
9. AGE (In years last birthday) <u>88</u> yns.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>DENNIS HOGON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edwin Wadsworth, atty. St. Michaels</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Dis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>6 mon.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>58</u> , to <u>10 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 Sept</u> , 19 <u>58</u> , and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Paul Chaffin</u>		DATE SIGNED <u>Box 487, St. Michaels, Md 9-11-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Sept 12, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hampton Harrison, St. Michaels, Md</u>		24a. REC'D BY REGISTRAR <u>9/12/58</u>	
24b. REGISTRAR'S SIGNATURE <u>A. Jenkins</u>		DATE <u>SEP 15 1958</u>	

Arthur S. Fraser

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11739

10580

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORFOLK</u> 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilbert</u> Middle <u>Demmery</u> Last		4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>40</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>R.C. 6:30P</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found lying by roadside-unconscious 9/24</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>nr Easton</u>	20f. (City or town) (County) (State) <u>Talbot Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lewis M. Welty</u>		DATE SIGNED <u>9-27-58</u>	
EXAMINER'S NAME (Type) <u>WELTY</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>L</u>	22b. DATE THEREOF <u>10-7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Marshall</u>		24. REC'D BY REGISTRAR DATE <u>OCT 8 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

10581

CERTIFICATE OF DEATH

10577

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>X Oxford</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Dobson</u>				4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1919</u>	
9. AGE (In years lost birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>30</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>3</u> Days <u>30</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Pinkney Parrott</u>				14. MOTHER'S MAIDEN NAME <u>Mary Dieffenderfer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>217-03-4019</u>		17. INFORMANT <u>Kease Dobson</u> Address <u>Oxford Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Westinghouse St</u> DATE SIGNED <u>20/58</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				M.D. <u>Easton 10, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oxford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maura C. Lewandowski</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 6/58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10581

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1891		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Retired		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. DECEASED AT HOME <input checked="" type="checkbox"/>		12. DECEASED IN HOSPITAL <input type="checkbox"/>		13. DECEASED IN NURSING HOME <input type="checkbox"/>		14. DECEASED IN OTHER PLACE <input type="checkbox"/>		15. PLACE OF DEATH Home	
16. DATE OF DEATH 1958		17. TIME OF DEATH 10:00 AM		18. CAUSE OF DEATH Heart Disease		19. MANNER OF DEATH Natural		20. MEDICAL ATTENDANT Dr. J. H. Smith	
21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESSES John D. Jones, Mary E. Smith		23. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		24. SIGNATURE OF REGISTRAR John D. Jones		25. SIGNATURE OF CLERK Mary E. Smith	

RECEIVED
BALTIMORE, MD
JAN 10 1958

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health. 2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person who attended the deceased. 3. The manner of death should be stated as either natural, accidental, or homicidal. 4. The medical attendant should be the physician who attended the deceased during his or her last illness. 5. The witnesses should be two persons who were present at the death of the deceased. 6. The registrar should be a person who is qualified to fill out this certificate. 7. The clerk should be a person who is qualified to fill out this certificate. 8. This certificate is valid for a period of 10 days after the date of death. 9. This certificate is subject to the provisions of the Maryland Health Code. 10. This certificate is subject to the provisions of the Maryland Health Code.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>22 hr. 45 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Hillsboro</u> <u>05X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Rufus</u> Middle <u>Downes</u> Last <u>Downes</u>		4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1 1905</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Downes</u>		14. MOTHER'S MAIDEN NAME <u>L. V. V.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Ruth Chambers Denton, Md</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>445X</u> DUE TO <u>Cardioid nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Maligant essential hypertension</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>(?)</u> <u>(?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u> </u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>22 Sept</u> , 19 <u>58</u> , to <u>23 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>22 Sept</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u>		ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>25 Sept 58</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>		M.D. <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown</u>	22d. LOCATION (City, town, or county) (State) <u>Hillsboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J B Dushnell</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10603 CERTIFICATE OF DEATH

10579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cedron</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cedron</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Francis</u> First <u>Voshey</u> Middle <u>Dubin</u> Last				4. DATE OF DEATH <u>Sept. 20</u> Month <u>20</u> Day <u>1958</u> Year			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8, 1891</u>		9. AGE (In years last birthday) <u>67</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P. Dubin</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Voshey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chas. A. Dubin</u>		Address <u>Cedron Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Chole cystitis</u> <u>585x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept. 18</u> , 19 <u>58</u> , to <u>Sept 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.				ADDRESS (Street, city or town, state) <u>Croftsville Md</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>9/22/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 24, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) <u>Croftsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Carter</u> ADDRESS <u>Croftsville Md</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>SEP 29 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

105E3

CERTIFICATE OF DEATH

Reg. Dist. No.

10580

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>12 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1 Bellevue</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence E Gibson</u>		4. DATE OF DEATH <u>9 23 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left upper lobe of the lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:58</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S Washington St, Easton, Md.</u> DATE SIGNED <u>23 Sept 58</u>			
ACTUAL SIGNATURE <u>E. C. H. Schmitt</u>		PHYSICIAN'S NAME (Type) <u>E. C. H. Schmitt</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 1 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

100

10584

CERTIFICATE OF DEATH

10581

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON MARYLAND</u>				c. LENGTH OF STAY IN 1b <u>7 DAYS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON MEMORIAL HOSPITAL</u>				e. STREET ADDRESS <u>1 MORRIS ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MR. HERBERT RICHARDSON GIBSON</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 21 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 17 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>MR. JOHN F. GIBSON</u>				14. MOTHER'S MAIDEN NAME <u>JADIE B. RICHARDSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES No 1908 - 1938</u>		16. SOCIAL SECURITY NO. <u>220-12-0380</u>		17. INFORMANT <u>Miss BETTY ANN GIBSON</u>		Address <u>OXFORD, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic brain tumor</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung</u> DUE TO (c) <u>(?)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic obstructive pulmonary emphysema</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1949</u> , 19 <u>58</u> to <u>24 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>21 Sept</u> , 19 <u>58</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u>				ADDRESS (Street, city or town, state) <u>Easton Maryland</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				DATE SIGNED <u>24 Sept 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept 24, 58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u>		22d. LOCATION (City, town, or county) (State) <u>Oxford MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hume</u>				ADDRESS <u>Easton MD</u>		24a. REC'D BY REGISTRAR <u>DEP 29 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10604

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. Bay nr Tilghman	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LARKINGTON - EDGEWATER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Route #1, Box 167 02 x-2	
3. NAME OF DECEASED (Type or print) FRANCIS W GILES		DATE OF DEATH Sept 14 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 22, 1925
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRAFTSMAN		10b. KIND OF BUSINESS OR INDUSTRY WISCONSIN	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME FRANCIS W. GILES		14. MOTHER'S MAIDEN NAME NELLIE MODER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WN II	
17. INFORMANT MRS. BETTY E. GILES. (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental drowning 850 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) body recovered Sept. 17 9AM nr Tilghman		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from cabin cruiser anchor rope wrapped about right arm -		
20c. TIME OF INJURY Month, Day, Year c 4 a.m. 9-14 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ches. Bay	20f. (City or town) (County) (State) nr. Bloody Pt. Q.A. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Lavin M. Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WE LTY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-17-58	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF Sept 19, 1958	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Moore Tilghman Md		24a. REC'D BY REGISTRAR SEP 19 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kneel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, place "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
HEALTH DEPT.

1915

MARYLAND STATE DEPARTMENT OF HEALTH - BANNINGHAM 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME *John W. Smith*
AGE *45*
SEX *Male*
DATE OF DEATH *Jan 15 1915*
PLACE OF DEATH *Home*
CAUSE OF DEATH *Acute Myocardial Infarction*
MANNER OF DEATH *Natural*
SIGNATURE OF EXAMINER *John W. Smith*
DATE *Jan 15 1915*

☐ Sudden Death
☐ Suicide
☒ Natural
☐ Homicide
☐ Accidental
☐ Unnatural

☐ Heart Disease
☐ Lung Disease
☐ Stomach Disease
☐ Liver Disease
☐ Kidney Disease
☐ Brain Disease
☐ Other

10585

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>42 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				1 d. STREET ADDRESS <u>Southwind</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mildred Elom Harker.</u>				4. DATE OF DEATH Month Day Year <u>September 17 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Massac</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edwin Elom</u>				14. MOTHER'S MAIDEN NAME <u>Kathleen Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spongioblastoma of brain</u> 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>15 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>Sept. 17</u> , 1958, that I last saw the deceased alive on <u>9-17</u> , 1958, and that death occurred at <u>6:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William L. Winters</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>210 E DOVER - EASTON Md. 9-18/58</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept. 19, 58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR DATE <u>SEP 22 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH Jan 5, 1928	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Attorney	
7. MARITAL STATUS Single		8. COLOR OF HAIR Brown	
9. COLOR OF EYES Blue		10. COLOR OF SKIN Caucasian	
11. PLACE OF DEATH Baltimore, Maryland		12. DATE OF DEATH April 4, 1968	
13. TIME OF DEATH 4:00 PM		14. CAUSE OF DEATH Heart Disease	
15. MANNER OF DEATH Natural		16. SIGNATURE OF PHYSICIAN [Signature]	
17. SIGNATURE OF REGISTRAR [Signature]		18. SIGNATURE OF WITNESS [Signature]	

1. This certificate is to be filled out by the physician attending the deceased or by the medical examiner or by the coroner or by the registrar of the health department.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or medical examiner or coroner or registrar.

3. The manner of death should be stated as natural, accidental, suicidal, homicidal, or undetermined.

4. The signature of the physician or medical examiner or coroner or registrar must be written in ink.

5. The date of death must be written in ink.

6. The place of death must be written in ink.

7. The name of the deceased must be written in ink.

8. The sex of the deceased must be written in ink.

9. The age of the deceased must be written in ink.

10. The color of the hair, eyes, and skin must be written in ink.

11. The marital status of the deceased must be written in ink.

12. The occupation of the deceased must be written in ink.

13. The time of death must be written in ink.

14. The cause of death must be written in ink.

15. The manner of death must be written in ink.

16. The signature of the physician or medical examiner or coroner or registrar must be written in ink.

17. The signature of the registrar must be written in ink.

18. The signature of the witness must be written in ink.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 5, Film G234, 10/3/58 for
CERTIFICATE OF DEATH

10584

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 S. Aurora St.		d. STREET ADDRESS 208 S. Aurora St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle S. Last HUBBARD		4. DATE OF DEATH Month Sept. Day 24, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months 81 Days 81 Hours 81 Min. 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Hubbard		14. MOTHER'S MAIDEN NAME Martha Blades	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Emily Hubbard		Address 208 S. Aurora St. Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.2 Acute Perforated Hemorrhage DUE TO (b) Acute Mesenteric Obstruction DUE TO (c) Adhesive band Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2-3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/19 , 19 58 , to 9/24 , 19 58 , that I last saw the deceased alive on 9/20 , 19 58 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED 9/27/58			
ACTUAL SIGNATURE L. J. Eglseder M.D.			
PHYSICIAN'S NAME (Type) Dr. L. J. Eglseder			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27, 1958	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10587

CERTIFICATE OF DEATH

Reg. Dist. No. 10585

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. Michaels</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>L</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1874</u>	9. AGE (In years last birthday) <u>84</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PLUMBER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>MARYLAND</u>		
13. FATHER'S NAME <u>Silas F. Lewis</u>			14. MOTHER'S MAIDEN NAME <u>KATHERINE SINCLAIR</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>ischemia severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cerebro + cardio</u> DUE TO <u>vascular.</u> (c) <u>vascular.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>advanced senile changes, arteriosclerotic changes, hypertrophy of heart</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>9-24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-24</u> , 19 <u>58</u> , and that death occurred at <u>7:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Guy M. Preeder Jr.</u>			ADDRESS (Street, city or town, state) <u>St Michaels Md</u>				
PHYSICIAN'S NAME (Type) <u>Guy M. Preeder Jr.</u>			DATE SIGNED <u>9-24-58</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)				
<u>Burial</u>	<u>Sept 26 1958</u>	<u>Christ Cemetery</u>	<u>St. Michaels Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Hamerton Harris</u>			24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE			
<u>St. Michaels Md</u>			DATE <u>SEP 29 '58</u>	<u>Arthur S. Huns</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10586

10605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St Micheals		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Charles Clyde Middle Lord Last		4. DATE OF DEATH Month Sept. Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 68 Days 68 Hours 68 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Farms	
11. BIRTHPLACE (State or foreign country) Preston		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert F. Lord		14. MOTHER'S MAIDEN NAME Mary Emily Willoughby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 218-16-6264	
17. INFORMANT Donald Lord		Address Preston	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x DUE TO chronic pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 37 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x Cerebral hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11 Aug , 19 58 , to 17 Sept , 19 58 , that I last saw the deceased alive on 16 Sept , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Carle Maryland DATE SIGNED 19 Sept 58			
ACTUAL SIGNATURE Harvey Harrison M.D.		PHYSICIAN'S NAME (Type) TITURSTON HARRISON	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 19	22c. NAME OF CEMETERY OR CREMATORY Jr. Order Cemetery	22d. LOCATION (City, town, or county) (State) Preston, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Harrison		24a. REC'D BY REGISTRAR DATE SEP 24 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON, MASS.
JANUARY 1, 1900
1900

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF REINTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10587

Reg. Dist. No.

10606

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) outside EASTON		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MILERIVER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alexander TAIT MCCORMICK		4. DATE OF DEATH 9-13-58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18 1892
9. AGE (in years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) STATE Roads GMN MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JOHN T. MCCORMICK		14. MOTHER'S MAIDEN NAME ISABELLE McCORMACK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 220-24-3598	
17. INFORMANT Mr. Thomas Andrews Easton Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACCIDENTAL DROWNING 850x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL FROM BOAT WHILE CRABBING	
20c. TIME OF INJURY Month, Day, Year ? Noon 9-14-58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MILES RIVER	20f. (City or town) (County) (State) NR. EASTON TALBOT MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis O'Neely		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WELTK		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-15-58	
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF 9/16/58	22c. NAME OF CEMETERY OR CREMATORY Greenmount	22d. LOCATION (city, town, or county) (State) Millsboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman		24. REC'D BY REGISTRAR SEP 19 '58	
ADDRESS Easton Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1950

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Undertaker: _____

18. Signature of Burial: _____

19. Signature of Cremation: _____

20. Signature of Other: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G234 10-16-58 et

10588

10607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe				c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS X Trappe			
3. NAME OF DECEASED (Type or print) First Julia Middle R Last Mc Daniel				4. DATE OF DEATH Month 9 Day 11 Year 1958			
5. SEX F	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/87 1888	9. AGE (In years last birthday) 7D yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory				10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Mckrey				14. MOTHER'S MAIDEN NAME Mary Ann Mackrey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Clayton Mc. Daniel, Easton, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 591X DUE TO Acute parenchymatous nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 7-8 min. DUE TO Exposure to weather (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 7, 1958 to Sept 11, 1958 , that I last saw the deceased alive on Sept 11, 1958 , and that death occurred at Easton, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED Sept 13, 1958							
ACTUAL SIGNATURE Hayward T. G. G. M.D.				DATE SIGNED Sept 13, 1958			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/58		22c. NAME OF CEMETERY OR CREMATORY Trappe Cem.		22d. LOCATION (City, town, or county) (State) Trappe Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE SEP 23 '58	
				24b. REGISTRAR'S SIGNATURE C. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10588

CERTIFICATE OF DEATH

Reg. Dist. No.

10589

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norton</u> <u>RFD #1 Box 171</u>				d. STREET ADDRESS <u>None 05x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 28 1902</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u> Hours <u>17</u> Min. <u>11</u>		IF UNDER 24 HRS. Months <u>5</u> Days <u>27</u> Hours <u>17</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State of foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Lewis C. Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Elizabeth Hill Greensboro Md.</u> Address <u>Greensboro Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anuria</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Kidneys Bilat</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post-op at nephrectomy</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/23</u> , 19 <u>58</u> , to <u>9/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/27/58</u> , 19 <u>58</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. P. Garnett</u> M.D.				ADDRESS (Street, city or town, state) <u>Dover Street Easton, Md</u> DATE SIGNED <u>Oct 1 '58</u>			
PHYSICIAN'S NAME (Type) <u>J. H. P. GARNETT M.D.</u>				<u>DOVER ST. EASTON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Near Goldsboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Bouclair</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES H. HARRIS		Male		45		White		Farmer	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. CAUSE OF DEATH	
Maryland		Jan 15, 1873		Maryland		Jan 15, 1918		Heart Disease	
11. PLACE OF INTERMENT		12. NAME OF MINISTER		13. NAME OF FUNERAL HOME		14. NAME OF UNDERTAKER		15. NAME OF CEMETERY	
St. Paul's Episcopal Church		Rev. J. H. Smith		J. H. Smith		J. H. Smith		St. Paul's Episcopal Church	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF MINISTER		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF UNDERTAKER	
		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF MINISTER		24. SIGNATURE OF FUNERAL HOME		25. SIGNATURE OF UNDERTAKER	
		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, 18

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10589

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN 1b <u>6 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> <u>05x-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>None</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>A</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 2, 1938</u> 19 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>19</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roland Clark</u>		14. MOTHER'S MAIDEN NAME <u>Odella Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Easton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Fractures, Internal Yugen</u> <u>825x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-13-58</u> Hour <u>4</u> o. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Rural Route Caroline Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dawson O. George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson O. George</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Henry Burial Ground</u>
		22d. LOCATION (City, town, or county) (State) <u>Ridgely, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouleis</u>		ADDRESS <u>Greensboro, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 4, Film G-233 9/19/58.cag
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10590
CERTIFICATE OF DEATH

10591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hospital</u>				d. STREET ADDRESS <u>Preston</u> 05X-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Nepert</u> Last <u>Nepert</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 20</u> <u>1905</u>	
9. AGE (In years last birthday) <u>45.3</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>5</u> Hours <u>3</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bulldozer operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Peter Nepert</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Schneidmiller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-16-5655</u>			
17. INFORMANT <u>Earl Nepert (son)</u>				Address <u>Preston</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>< 6 hrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>D.O.A.</u> , 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>9-14-58</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D. <u>Medical Arts Bldg.</u>							
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u> <u>202 Dover St., Easton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Sept 16, 1958</u>		<u>Winchester Cemetery</u>		<u>Preston, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Williams - Federalburg, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>9-14-58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10592

10591

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>20A@10:20pm 40</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>29 Ad Kins Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William Ouid Norwood</u> First Middle Last 4. DATE OF DEATH <u>September 7 1958</u> Month Day Year		5. SEX <u>m</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 28, 1910</u> 9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Ouid Norwood</u>		14. MOTHER'S MAIDEN NAME <u>Eva Riggan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. Welch</u> EXAMINER'S NAME (Type) <u>WIE LTY</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-8-58</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Silver Brook Crem.</u>		22d. LOCATION (City, town, or county) (State) <u>Williamston Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maunce E. Lewman & Son, Easton Md.</u>		24a. REGISTERED REGISTRAR <u>SEP 10 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 1591

FOR DATE
HEALTH NO.

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of medical examiner	
10. Signature of attending physician		11. Signature of coroner		12. Signature of registrar	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of mortician		17. Signature of embalmer		18. Signature of transporter	
19. Signature of funeral home		20. Signature of funeral home		21. Signature of funeral home	
22. Signature of funeral home		23. Signature of funeral home		24. Signature of funeral home	
25. Signature of funeral home		26. Signature of funeral home		27. Signature of funeral home	
28. Signature of funeral home		29. Signature of funeral home		30. Signature of funeral home	
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64. Signature of funeral home		65. Signature of funeral home		66. Signature of funeral home	
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73. Signature of funeral home		74. Signature of funeral home		75. Signature of funeral home	
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91. Signature of funeral home		92. Signature of funeral home		93. Signature of funeral home	
94. Signature of funeral home		95. Signature of funeral home		96. Signature of funeral home	
97. Signature of funeral home		98. Signature of funeral home		99. Signature of funeral home	
100. Signature of funeral home		101. Signature of funeral home		102. Signature of funeral home	

CERTIFICATE OF DEATH

Reg. Dist. No.

10608

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>		c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton 40</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Rio Vista Nursing Home</u>		d. STREET ADDRESS <u>423 E. Dover St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hazel</u> First <u>Findaly</u> Middle <u>Parlett</u> Last		4. DATE OF DEATH <u>Sept</u> Month <u>22</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Easton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benj F. Parlett</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Grace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Henry Purdy, Easton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>422.1</u> DUE TO <u>arteriosclerotic cerebro and cardiac vascular d.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>advanced senile changes, coxidia generalizid.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>9-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-22</u> , 19 <u>58</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm M. Reece</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>9-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Wm M. Reece</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>New York N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams, Easton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 10

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

MANIFESTATION OF

PREEXISTING DISEASE

PREEXISTING DISEASE

PREEXISTING DISEASE

PREEXISTING DISEASE

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PREEXISTING DISEASE

CERTIFICATE OF DEATH

Reg. Dist. No.

10594

10592

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>R.F.D #2</u>			
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>-</u> Last <u>Porter</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 20, 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Porter</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Garrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Russell Porter Denton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atrioventricular Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of bladder</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While o. m. p. m. <u>19</u> Not while o. m. p. m. <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/5/58</u> to <u>9/5/58</u> , that I lost saw the deceased alive on <u>9/4/58</u> , 19 <u>58</u> , and that death occurred at <u>10 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hugh Moore</u> ADDRESS <u>Denton, Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15523

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF BIRTH May 19, 1928		6. PLACE OF BIRTH Jackson, Mississippi	
7. DATE OF DEATH April 4, 1968		8. TIME OF DEATH 2:01 PM		9. PLACE OF DEATH Memphis, Tennessee		10. CAUSE OF DEATH Assault with a Dangerous Weapon		11. MANNER OF DEATH Homicide		12. ICD-9 CODE 94.0	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF WITNESSES	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF CLERK		21. SIGNATURE OF CHIEF OF POLICE		22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF JUDGE		24. SIGNATURE OF SHERIFF	

THIS CERTIFICATE OF DEATH IS A LEGAL DOCUMENT AND MUST BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, MISSISSIPPI DEPARTMENT OF HEALTH, BIRMINGHAM, MISSISSIPPI. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN A COMPLETE RECORD OF ALL DEATHS IN THE STATE OF MISSISSIPPI. THIS CERTIFICATE IS VALID FOR ALL PURPOSES INCLUDING THE ISSUANCE OF A BURIAL PERMIT AND THE FILING OF A PROBATE APPLICATION. IT IS THE DUTY OF THE PHYSICIAN TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE CORONER TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE JURY TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE WITNESSES TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE REGISTRAR TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE CLERK TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE CHIEF OF POLICE TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE DISTRICT ATTORNEY TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE JUDGE TO COMPLETE THIS CERTIFICATE AND SIGN IT. IT IS THE DUTY OF THE SHERIFF TO COMPLETE THIS CERTIFICATE AND SIGN IT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

10593

Item 2 Film G234 9/25/58 ggi

10595

10593

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carlton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>440 Carlton Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home For Aged Ladies</u>		d. STREET ADDRESS <u>1 St. Aurora Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Ellen Green Roman</u>		4. DATE OF DEATH <u>Sept - 16 1958</u>	
5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1876</u> 9. AGE (In years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick S. Green</u>		14. MOTHER'S MAIDEN NAME <u>Albena W. Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Home For Aged Ladies</u> Address <u>Carlton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/1/58</u> , to <u>9/16/58</u> , that I last saw the deceased alive on <u>9/1/58</u> , 19 <u>58</u> , and that death occurred at <u>2</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Carlton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Carlton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Caroline S. Hines</u>	

Item 20 Film 233 9-17-58 am

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Talbot

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland b. COUNTY Queen Anne

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Easton

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Stevensville

17X-2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

Waiter

First

Middle

Last

Roman

4. DATE
OF
DEATH

Month

Day

Year

9

6

1958

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

JAN. 10, 1925

9. AGE (In years
last birthday)

33 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

HIGH SCHOOL TEACHER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N. J.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Paul Roman

14. MOTHER'S MAIDEN NAME

MARY MIKLASIEWICH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

Yes

W.W. II

16. SOCIAL SECURITY NO.

17. INFORMANT

Janet Roman - Stevensville, Md.

18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

2ot embolism

Multiple fracture

Automobile accident

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Speed - lost control

20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m.

9-1-58

20d. INJURY OCCURRED
While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Highway

20f. (City or town)

nr. Stevensville

(County)

QA

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

W. Henry Fisher

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9/8-58

EXAMINER'S
NAME (Type)

W. HENRY FISHER

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

9/1/58

22c. NAME OF CEMETERY OR CREMATORY

Kent Island

22d. LOCATION (City, town, or county)

Stevensville

(State)

Md

23. FUNERAL DIRECTOR'S SIGNATURE

ES Lane Churchill

24a. REC'D BY REGISTRAR

DATE SEP 15 '58

24b. REGISTRAR'S SIGNATURE

Arthur E. Hume

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1958

DATE OF DEATH

EXAMINED AT

THE FOLLOWING PLACE

1. Name of deceased

2. Sex

3. Age

4. Race

5. Occupation

6. Usual place of abode

7. Date of birth

8. Date of death

9. Cause of death

10. Manner of death

11. Signature of medical examiner

12. Signature of coroner

13. Signature of registrar

14. Signature of physician

10595

CERTIFICATE OF DEATH

10597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> 17X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>227 N. Liberty Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Pozier</u> Last <u>Pozier</u>				4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17, 1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charlie Goldsborough</u>				14. MOTHER'S MAIDEN NAME <u>Katie Clayton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT Address <u>Hospital Records - like Roger's husband</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>Unknown</u> Interval between onset and death <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X Pneumonia, rt. middle lobe, unknown organism</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-16</u> , 19 <u>58</u> , to <u>9-16</u> , 19 <u>58</u> that I last saw the deceased alive on <u>9-16</u> , 19 <u>58</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D. <u>202 Dover St.</u>							
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u> <u>Easton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 20-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centreville</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Bester</u> ADDRESS <u>100 Bester Bldg., Centreville Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11222

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

Reg. No. 11222

DATE OF BIRTH		DATE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH	
11-22-22		11-22-22		BALTIMORE, MD.		BALTIMORE, MD.	
SEX		AGE		OCCUPATION		CAUSE OF DEATH	
MALE		22		LABORER		HEART DISEASE	
MARRIED		SINGLE		BORN IN		DIED IN	
YES		NO		BALTIMORE, MD.		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
JOHN DOE		JANE DOE		LABORER		HOUSEWIFE	
FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH	
11-22-22		11-22-22		11-22-22		11-22-22	
FATHER'S PLACE		MOTHER'S PLACE		FATHER'S CAUSE		MOTHER'S CAUSE	
BALTIMORE, MD.		BALTIMORE, MD.		HEART DISEASE		HEART DISEASE	
FATHER'S DEATH		MOTHER'S DEATH		FATHER'S PLACE		MOTHER'S PLACE	
11-22-22		11-22-22		BALTIMORE, MD.		BALTIMORE, MD.	
FATHER'S CAUSE		MOTHER'S CAUSE		FATHER'S DEATH		MOTHER'S DEATH	
HEART DISEASE		HEART DISEASE		11-22-22		11-22-22	
FATHER'S PLACE		MOTHER'S PLACE		FATHER'S CAUSE		MOTHER'S CAUSE	
BALTIMORE, MD.		BALTIMORE, MD.		HEART DISEASE		HEART DISEASE	
FATHER'S DEATH		MOTHER'S DEATH		FATHER'S PLACE		MOTHER'S PLACE	
11-22-22		11-22-22		BALTIMORE, MD.		BALTIMORE, MD.	
FATHER'S CAUSE		MOTHER'S CAUSE		FATHER'S DEATH		MOTHER'S DEATH	
HEART DISEASE		HEART DISEASE		11-22-22		11-22-22	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE FEDERAL BUREAU OF INVESTIGATION.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10609

CERTIFICATE OF DEATH

10598

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1119 MULBERRY</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>M.</u> Last <u>SEWELL</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 29 1864</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ST. MICHAELS MD</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>BENJAMIN BLADES</u>				14. MOTHER'S MAIDEN NAME <u>EMILY ROBINSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Elves Sewell, St. Michaels, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X coecheia - generalized</u> DUE TO <u>arteriosclerotic cerebro-vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>advanced senile changes.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-5</u> , 19 <u>58</u> , to <u>9-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-18</u> , 19 <u>58</u> , and that death occurred at <u>2:47</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St. Michaels md</u> DATE SIGNED <u>9-19 58</u>							
ACTUAL SIGNATURE <u>Guy M. Reiser Jr</u> M.D.				PHYSICIAN'S NAME (Type) <u>Guy M. Reiser Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 20, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Harrison</u>				ADDRESS <u>St. Michaels, Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

10596

CERTIFICATE OF DEATH

10599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b RESIDENT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 417 Goldsborough		e. STREET ADDRESS 1417 Goldsborough St.	
3. NAME OF DECEASED (Type or print) First IRA Middle SIKES Last SIKES		4. DATE OF DEATH Month 9 Day 26 Year 1958	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 26 Hours 19 Min. 58	11. IF UNDER 24 HRS. Months 7 Days 26 Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Hardware	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-34-3146	
17. INFORMANT Address Easton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral thrombosis with right hemiparesis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 332X		(c) Chronic renal disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic renal disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 19 , and that death occurred at 5:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Trever		ADDRESS (Street, city or town, state) 202 Dover St.	
PHYSICIAN'S NAME (Type) ROBERT W. TREVER M.D.		DATE SIGNED 9-26-58	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/58	
22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleis		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR SEP 30 58		24b. REGISTRAR'S SIGNATURE Ciriling L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10597

CERTIFICATE OF DEATH

Reg. Dist. No.

10600

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Rhodesdale 09x-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>S.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>CO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17 1916</u>		9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAY LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Smith</u>				14. MOTHER'S MAIDEN NAME <u>Alice (MAIDEN NAME UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-7174</u>		17. INFORMANT Address <u>ADAM W. WASHINGTON, VIENNA, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Acute renal tubular necrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic essential hypertension</u> (c) <u>Chronic essential hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>171</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 day</u> 19 <u>58</u> , to <u>26 Sept</u> 19 <u>58</u> , that I last saw the deceased alive on <u>25 Sept</u> 19 <u>58</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Carlton, Maryland</u> DATE SIGNED <u>26 Sept 58</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FEDERAL HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson</u> ADDRESS <u>See Federalsburg Md.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

Form 100-1

<p>1. NAME OF DECEASED <i>JOHN J. JONES</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1937</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Md</i></p>	
<p>10. OCCUPATION <i>Engineer</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. COLOR <i>White</i></p>	
<p>13. EDUCATION <i>High School</i></p>		<p>14. RELIGION <i>Catholic</i></p>		<p>15. PREVIOUS ILLNESS <i>None</i></p>	
<p>16. SIGNATURE OF PHYSICIAN <i>John J. Jones</i></p>		<p>17. SIGNATURE OF DECEASED <i>John J. Jones</i></p>		<p>18. SIGNATURE OF WITNESS <i>John J. Jones</i></p>	
<p>19. SIGNATURE OF REGISTRAR <i>John J. Jones</i></p>		<p>20. SIGNATURE OF CLERK <i>John J. Jones</i></p>		<p>21. SIGNATURE OF JURY <i>John J. Jones</i></p>	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10601

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL QUEEN ANNE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL QUEEN ANNE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle LEON Last TRICE		4. DATE OF DEATH Month SEPT. Day 14 Year 1958	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 25, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) — yrs. 1 Months 20 Days — Hours — Min. —	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME EDGAR TRICE		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME JOAN WILSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT EDGAR TRICE Address QUEEN ANNE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastro-enteritis DUE TO (c) Prematurity			INTERVAL BETWEEN ONSET AND DEATH 1-2 WKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-13 , 19 58 , to 9-14 , 19 58 , that I last saw the deceased alive on 9-14 , 19 58 , and that death occurred at 9 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph E. Johnson III M.D.		ADDRESS (Street, city or town, state) Queen Anne, Md DATE SIGNED 9-15-58	
PHYSICIAN'S NAME (Type) Joseph E. Johnson III			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Sept 16, 1958	22c. NAME OF CEMETERY OR CREMATORY Union	22d. LOCATION (City, town, or county) (State) Greenboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Hines ADDRESS Greenboro, Md.		24a. REC'D BY REGISTRAR SEP 18 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

2080203XV4

10598

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock	
c. LENGTH OF STAY IN 1b 9 days		d. STREET ADDRESS 09x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eda Middle B. Last Van Orden		4. DATE OF DEATH Month 9 Day 8 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Oregon		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Kruger		14. MOTHER'S MAIDEN NAME Anna Spencer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary thromboses 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 219 S. West 117th St DATE SIGNED 9/5/58			
ACTUAL SIGNATURE E.C.H. Schmidt M.D.		PHYSICIAN'S NAME (Type) Easton 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth S. Kellough ADDRESS East New Market		24a. REC'D BY REGISTRAR SEP 15 '58	
24b. REGISTRAR'S SIGNATURE Charles S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown 17X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>W. A.</u> Middle <u>Queen</u> Last <u>Yewell</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 20, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William R. Yewell</u>		14. MOTHER'S MAIDEN NAME <u>MARY L. TARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-20-4578</u> 17. INFORMANT <u>McGeorge A. Yewell, Centreville Maryland</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Psychonephritis</u> (c) <u>Nephrosclerosis</u> <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2:45</u> , 19 <u>58</u> , to <u>2:45</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2:45</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		DATE SIGNED <u>2195 W 257 117 17 ST. 8 Sept 58</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Centron 16 Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 10, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christyfield Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Boring, Jr. Centreville, Md.</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>SEP 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

